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SOCIAL STRATIFICATION AND PSYCHIATRIC PRACTICE: A STUDY OF AN OUT-PATIENT CLINIC *

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THIS paper is an analysis of the relationship between social class and the selection and treatment of patients in a psychiatric out-patient clinic. It grew out of another research project in which the authors are engaged.[1] In that study a significant relationship was found between the social class background of patients and the type of psychiatric treatment they received.[2] There was a distinctly higher percentage of patients receiving some form of *psychotherapy* in the upper social classes. In contrast, the percentage of persons receiving *custodial care* only or some form of *organic therapy* was greater in the lower social classes.

Because of the significance of these findings, the present authors studied the relationship between social class and psychiatric treatment in more detail, examining a setting where only one type of treatment (psychotherapy) was administered and where most patients had the same disorder (neurosis). In the process was tested an economic explanation offered by many psychiatrists for the findings of the study mentioned above.

Most psychotherapy is administered in private practice and is expensive. It was argued, therefore, that lower class people cannot afford such treatment. There is reason to believe, however that the economic explanation is not wholly satisfactory. Therefore, the authors examined the records of all cases (195 in number)[3] that came to the clinic from October 1, 1950 to September 30, 1951, to determine if social class was related to: (1) acceptance for treatment, and (2) nature of treatment as measured by (a) training and status of the therapist, (b) duration of treatment, and (c) intensity of treatment.

The institution is a training and community clinic where treatment is oriented around expressive psychotherapy. Such therapy is verbal and interpersonal in nature, and based upon fundamental psychoanalytic principles. It requires relatively long and intensive contact between patient and therapist. Anyone with an income of under 5,000 dollars a year and residing within a given geographic area is eligible for care, and the fees charged are nominal and scaled. On theoretical grounds, if ability to pay were the important component in psychotherapy, we would expect that acceptance for therapy and the character of subsequent experience in the clinic would not be related to the patient's social class. This hypothesis was deduced from the economic arguments advanced by psychiatrists to explain the differential association of therapy with social class in the earlier, more comprehensive study.

ANALYSIS OF THE DATA

The clinic's procedure in selecting patients was as follows: If an individual seeking psychiatric help met the clinic's residential and financial requirements, he was

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* Paper read at the annual meeting of the American Sociological Society, August, 1953. At the time of the research, Dr. Schaffer was a Post-Doctoral Research Fellow of the National Institute of Mental Health, U.S.P.H.S., F.S.A.

[1] A. B. Hollingshead and F. C. Redlich, "The Relationship of Social Structure to Psychiatric Disorders" aided by U.S.P.H.S. Mental Health Act Grant MH 263(R).

[2] F. C. Redlich, A. B. Hollingshead, *et al.*, "Social Structure and Psychiatric Disorders," *American Journal of Psychiatry,* 109 (April, 1953), pp. 729–34; A. B. Hollingshead and F. C. Redlich, "Social Stratification and Psychiatric Disorders," *American Sociological Review,* 18 (April, 1953), pp. 163–69; H. A. Robinson, F. C. Redlich, and J. K. Myers, "Social Structure and Psychiatric Treatment," in press for *American Journal of Orthopsychiatry;* B. H. Roberts and J. K. Myers, "Religion, National Origin, Immigration, and Mental Illness," *American Journal of Psychiatry,* 110 (April, 1954), pp. 759–64.

[3] Twelve cases which could not be class-typed because of paucity of data were omitted from the following analysis.

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referred to an intake interviewer who was either a social worker or a psychiatrist. This interviewer obtained from the patient necessary information to present his case to an intake conference at which all the clinic's psychiatric personnel decided whether or not therapy should be administered. All of the patients accepted by the intake interviewer became the subjects of our study. We classified these individuals operationally according to a method described in a previous paper,[4] using a five-class system developed by Hollingshead, in which the highest status group is labeled class I, with the others following in numerical order, class V being the lowest.[5]

The social class distribution of persons seen by the intake interviewer was as follows: class II-9 per cent, class III-28 per cent, class IV-39 per cent, and class V-23 per cent.[6] It is clear that persons from all social classes, except the highest, sought aid at the clinic. Whether or not an individual was recommended for treatment, however, was directly related to his social class position as can be seen in Table 1. Nearly two-thirds of class V persons were not recommended for therapy, compared to about one-fifth of persons in class IV and only one-tenth of those in classes II and III. Certainly the economic hypothesis is not supported by these findings.

Just as interesting is the fact that there was a significant difference in the training of the personnel assigned to treat patients in the various social classes. The trained staff psychiatrists treated mainly class II and class III patients; resident psychiatrists in training treated class III and class IV patients; and medical students, taking a four week course, treated class IV and class V patients. The fully trained staff did not treat any patients in class V and only two in class IV. In contrast, medical students with no previous experience in psychotherapy treated no patients in class II and only five in class III.

The third relationship between class position and treatment was that the duration of therapy varied significantly from one class to another. The data in Table 2 show that the higher a patient's social class, the longer his treatment. The percentage of persons receiving treatment for ten or more weeks increased from 14 in class V to 59 in class II. On the other hand, nearly half of all class V patients were seen less than one week, but only 12 per cent of

TABLE 1. PERCENTAGE DISTRIBUTION OF PATIENTS BY SOCIAL CLASS AND INTAKE CONFERENCE DECISION

Conference Decision	Social Class II	III	IV	V
No treatment recommended	11.8	9.6	22.2	64.3
Assigned to staff	35.3	17.3	2.8	.0
Assigned to resident psychiatrist	29.4	38.5	30.6	2.4
Assigned to medical student	.0	9.6	26.4	23.8
Assigned to other therapist (social workers, psychology students)	5.9	7.7	9.7	7.1
Referred to other agencies	11.8	17.3	4.2	2.4
Unknown *	5.9	.0	4.2	.0
	100.1	100.0	100.1	100.0

Chi-square=81.7924, p less than .001.N=183.

* Unknown cases were not included in the chi-square computation.

[4] Redlich, Hollingshead, *et al., op. cit.*

[5] A brief description of each class is as follows: *Class I* comprises families of wealth, education, and top social prestige; *class II* consists of families in which the adults for the most part hold college degrees and in which the husbands have executive, high-level managerial, or professional occupations; *Class III* includes proprietors, white-collar workers, and some skilled workers; they are mostly high school graduates; *class IV* consists largely of semi-skilled workers with less than a high school education; *class V* includes unskilled and semi-skilled workers, who have a grade-school education or less, and who live in the poorest areas of the community.

[6] The social class distribution of the New Haven population is as follows: class I—3 per cent, class II—8 per cent, class III—21 per cent, class IV—50 per cent, and class V—18 per cent.

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those in class II were seen for such a short period.

The intensity of treatment, as measured by number of contacts with therapist, was also significantly greater in the higher social class. The percentage of persons seen ten or more times rose from 12 in class V to 53 in class II, and the percentage of persons seen only once declined from 45 in class V to 18 in class II.

TABLE 2. PERCENTAGE DISTRIBUTION OF PATIENTS BY SOCIAL CLASS AND DURATION OF CONTACT WITH CLINIC

Length of Contact	Social Class II	III	IV	V
Less than one week	11.8	26.9	37.5	47.6
1–9 weeks	29.4	26.9	33.3	38.1
10 or more weeks	58.8	46.2	29.2	14.3
	100.0	100.0	100.0	100.0

Chi-square=17.5029, p less than .01. N=183.

This relationship between the nature of treatment and the patient's social class is illustrated even more strikingly by analysis of only those cases assigned to a therapist at the intake conference, instead of all cases accepted initially.

As indicated in Table 4, the percentage of patients seen ten or more times declined from 75 in class II to only 29 in class V. These findings indicate clearly that lower class persons did not receive as long and intensive treatment as those higher in the class system.

It must be recognized that factors other than social class may be related to acceptance for treatment and subsequent therapeutic experience. Sex and age of the patient and professional status of the intake interviewer, suggested by psychiatrists as perhaps being relevant, were not. The chi square test was used, and significance was defined at the .05 level. Diagnosis, however, was found to be significantly related to acceptance and subsequent clinical experience. Although most patients were neurotics, approximately one-quarter were suspected of being psychotic and were treated differently. They were not accepted for therapy as frequently as neurotics and did not receive as long and intensive treatment by as highly trained personnel. This did not account for the differential treatment of patients by social class, however, since there was no significant difference in the class distribution of suspected psychotics and neurotics.

TABLE 3. PERCENTAGE DISTRIBUTION OF PATIENTS BY SOCIAL CLASS AND TOTAL NUMBER OF TIMES SEEN IN CLINIC

Times Seen	Social Class II	III	IV	V
One	17.6	23.1	38.9	45.2
2–9	29.4	28.8	40.3	42.9
10 or more	52.9	48.1	20.9	11.9
	99.9	100.0	100.1	100.0

Chi-square=22.5410, p less than .001. N=183.

TABLE 4. PERCENTAGE DISTRIBUTION OF PATIENTS ACCEPTED AT INTAKE CONFERENCE BY SOCIAL CLASS AND DURATION OF THERAPY

Times Seen	Social Class II	III	IV	V
1–9	25.0	36.8	70.0	71.4
10 or more	75.0	63.2	30.0	28.6
	100.0	100.0	100.0	100.0

Chi-square=15.4446, p less than .01. N= 114.

CONCLUSIONS AND INTERPRETATIONS

In summary, it was found that in a situation where the economic factor was held constant, acceptance for therapy and the character of subsequent clinical experience were related significantly to the patient's social class; the higher an individual's social class position, the more likely he was to be accepted for treatment, to be treated by highly trained personnel, and to be treated intensively over a long period.

Although the necessary data to explain these findings are lacking, some tentative explanations which might lead to further research are offered. It may be that differences in the social class backgrounds between psychiatrists, who are mainly from classes I and II, and class IV and V patients are important factors in the differential acceptance rates and subsequent clinic experience. Variations, according to social class, in the conception of the psychiatrist's role and the meaning of therapy

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seem important. For instance, the psychiatrist's values concerning who should be treated appear to influence the acceptance of patients. Also, lower class persons do not seem to share with psychiatrists the conception of therapy as a process by which the patient gains insight into his problems. Frequently, such patients conceive of the therapist's role in magical terms.

Psychotherapy involves intimate communicative interaction between the patient and therapist. Therefore it may be facilitated if a certain similarity in culturally determined symbols and learned drives exist in both patient and therapist. Differences in value systems and patterns of communication, on the other hand, may hamper the establishment of the therapeutic relationship. At present, it appears possible that lower-class patients need to acquire new symbols and values to participate in expressive psychotherapy. Since this is a difficult process, many of them may be considered unpromising candidates for successful treatment. According to the clinic's staff they often "lack motivation for psychotherapy" or are not "psychologically minded." Perhaps psychiatrists need to acquire new symbols and values in dealing with lower class patients; or perhaps new approaches are necessary to bring psychotherapy to such persons.

A STUDY OF SOCIAL STRATIFICATION USING AN AREA SAMPLE OF RATERS *

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IT is the purpose of this study to examine empirically, within the confines of a selected community, the conceptions of social stratification as described by an area sample of community members.

It has been the practice in empirical studies of social stratification for the researcher to select a group of raters or judges on the basis of qualifying criteria such as length of residence in the community or breadth of acquaintance with members of the community.[1] The implicit assumption in such studies is that some persons are better qualified than others to judge the social status of their fellow townsmen. With one noteworthy exception,[2] these studies have found that a distinct stratification pattern did indeed exist, and that it consisted of a fixed number of social strata. Such a pattern, however useful or accurate it may be, is the pattern as seen *from the perspective of the raters.* As the qualifications of the raters are increased in number, the perspective becomes more limited.

In constrast, the basic assumption of this study is that effective status judgments may be made by any or all members of a community who are in interaction, and that these judgments may furnish at least a partial basis for differential attitudes and behavior toward different categories of community members. Such a premise necessitated the use of a minimum number of qualifications for the selection of raters. Raters were therefore chosen at regular intervals from an ordered geographical pattern of dwellings.

"Social stratification pattern" was tentatively defined as an ideal construct of a

* Paper read at the annual meeting of the American Sociological Society, August, 1953.

[1] August B. Hollingshead, *Elmtown's Youth: The Impact of Social Classes on Adolescents,* New York: John Wiley & Sons, 1949; Gerhard E. Lenski, "American Social Classes: Statistical Strata or Social Groups?" *American Journal of Sociology,* LVIII (September, 1952), pp. 139–144; Raymond W. Mack, "Housing as an Index of Social Class," *Social Forces,* 29 (May, 1951), pp. 391–400; W. Lloyd Warner, Marchia Meeker, and Kenneth Eells, *Social Class in America: A Manual of Procedure for the Measurement of Social Status,* Chicago: Science Research Associates, 1949; James West, *Plainville, U.S.A.,* New York: Columbia University Press, 1945; and Wayne Wheeler, *Social Stratification in a Plains Community,* Minneapolis: Wayne Wheeler, 1949.

[2] Lenski, *op. cit.*

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